State of Rhode Island and Providence Plantations
Department of Health

DIVISION OF HEALTH SERVICES REGULATION

Complaint Form

Please fill in the Complaint Form completely, sign and date the form. Please be as clear and concise as possible. Type or print all information in black ink. Incomplete information may delay the investigation of your complaint.

Patient/Complainant Information

Name of Patient _____ , _____ ____ ____

Last First MI Suffix

Date of Birth (MM/DD/YYYY) _____

Address _____

_____

_____

Phone Number _____

Complainant (If Different from Above):

_____ , _____ ____ ____

Last First MI Suffix

Address _____

_____

_____

Phone Number _____

Relationship to Patient _____

Health Care Provider Information:

Name _____ , _____ _____ _____

Last First MI Suffix

Address _____

_____

_____

Phone Number _____

Type of License (MD; DO; RN; etc.) _____

Facility _____

Address _____

_____

_____

Phone Number _____

Managed Care Organization _____

Address _____

_____

_____

Phone Number _____

Complaint Information

Please attach a brief (1-2 page) summary of your complaint(s), then sign and date the Verification Statement below:

Regarding:

Verification Statement

I hereby verify that the attached statements in this complaint are true and accurate to the best of my knowledge and recollection and do affirm that this complaint is filed in good faith.

_____

Complainant Signature Date of Signature (MM/DD/YYYY)

Please enclose all copies of any pertinent information/documentation related to your complaint. Mail the completed Complaint form, Summary of Complaint, signed Release of Information Form and signed Verification Statement along with any other documentation to:

Complaint Unit
Division of Health Services Regulation
Rhode Island Department of Health
3 Capitol Hill
Providence, RI 02907-5098